RISK ASSESSMENT OF BLOODBORNE PATHOGEN EXPOSURE

(See DD Form 2005 for Privacy Act Statement)

PART I - ADMINISTRATIVE DATA

1a. Patient's name	1b. Family member prefix	1c. Social Security Number	1d. Military Rank
1e. Job title	1e. Worksite		
1f. Supervisor's name	1g. Name of primary care provider		
2a. Source's name	2b. Family member prefix	2c. Social Security Number	2d. Military Rank
2c. Source's physician's name	3. Date of injury	4. Site of injury	

5. Route of exposure ☐ Penetration of normal skin ☐ Contact with abraded or inflamed skin ☐ Contact with mucous membrane

6a. Printed name of person completing Part I	6b. Signature	6c. Date

PART II - RISK ASSESSMENT OF SOURCE

If the source is:

7. Source is unavailable. The source's primary care provider was contacted and a request regarding information pertaining to the patient's risk assessment, along with a request to order required blood work, was done. ☐ N/A ☐ No ☐ Yes - Date: _____

8. If source is available, he or she should accompany the exposed individual and the individual's supervisor to the post-exposure evaluation. The provider will evaluate the source and order the required blood work for the source:

a. HIV risk assessment
Known positive ☐ Yes ☐ No If "Yes," WR Stage: _____ Viral load count and date: _____
High risk *(Known or suspected intravenous drug user, known or suspected high number of sexual partners or prostitute, homosexual or bisexual activity, hemophiliac, hemodialysis, received blood products between 1976 and 1985, sexual contact or spouse of person in one of the above categories, immigrant from a high risk area, or signs or symptoms of HIV.)* ☐ Yes ☐ No
☐ Known negative titer, date: _____

b. Hepatitis B risk assessment *(select one)*
☐ Known positive for HbsAg, date: _____
☐ High risk *(Immigrant from high risk area for hepatitis B; household contact of known hepatitis B carrier; and or positive HIV risk factors.)*
☐ Known negative HbsAg: date: _____

c. Hepatitis C risk assessment *(select one)*
☐ Diagnosed as having hepatitis C, date: _____
☐ High risk *(Unexplained elevated SGOT or SGPT and hepatitis C suspected; hemodialysis patient who received transfused blood prior to August 1990.)*
☐ Known negative titer, date:

PART III - TESTING OF SOURCE

(Check all tests ordered.)

9. Required tests *(Check all that apply.)*	10. Additional blood work, if indicated
☐ HBsAg ☐ Anti-HBc ☐ Anti-HCV ☐ Anti-HIV ☐ HBeAg ☐ LFTs	☐ RPR

11. Other tests *(specify)*:

12. Sources tests to be ordered by *(specify)*:

13a. Physician's printed name or stamp	13b. Signature	13c. Date